

Lessons from the Ashes: Improving Transportation Safety Through Accident Investigation



2019 Westminster Lecture on Transport Safety

Robert Sumwalt, FRAeS

December 4, 2019



Our mission:
Prevent Accidents
Reduce Injuries
Save Lives





Bruce Landsberg



Robert Sumwalt



Jennifer Homendy

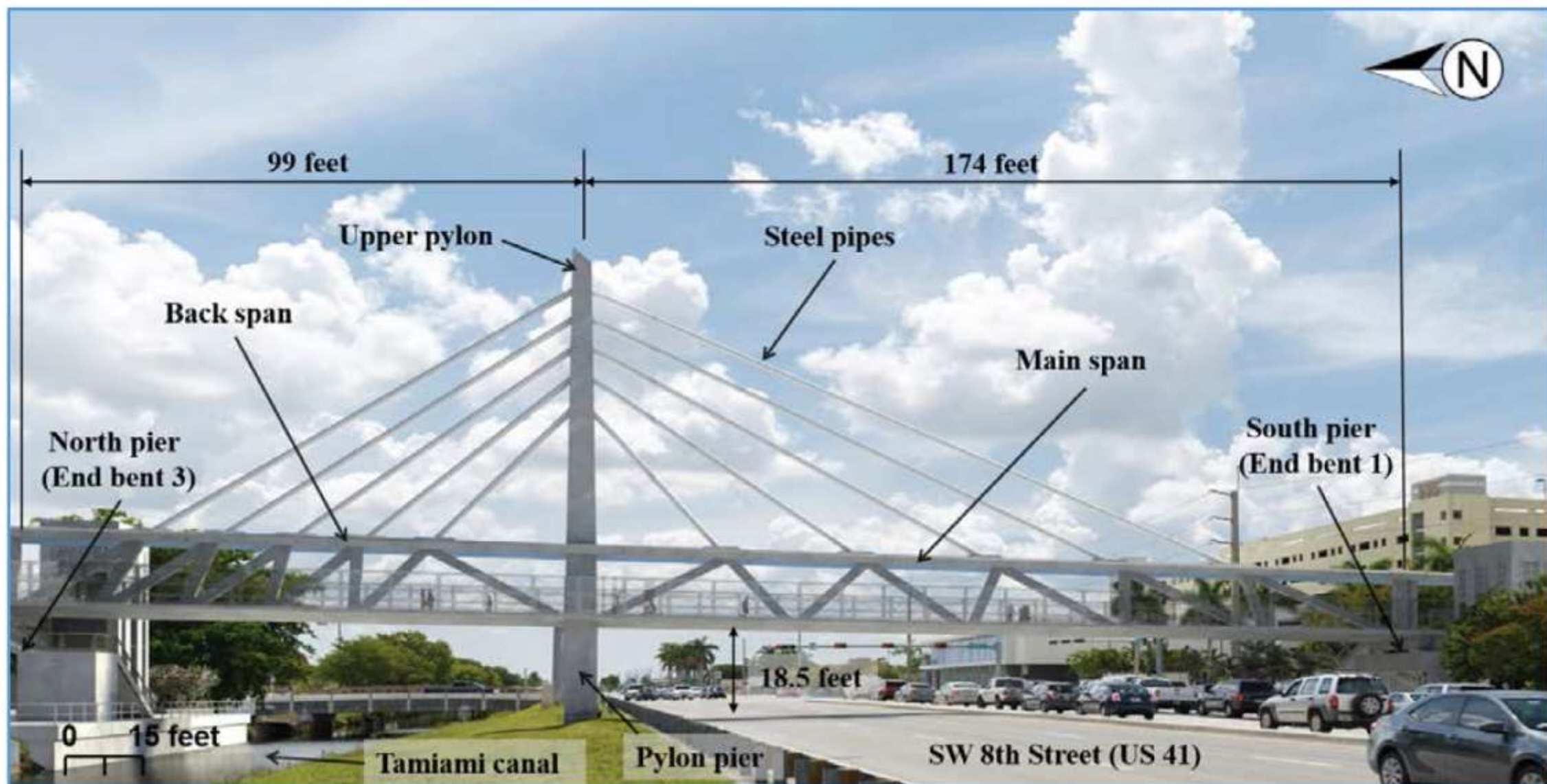




NTSB Response Operations Center







Miami, Florida. March 15, 2018



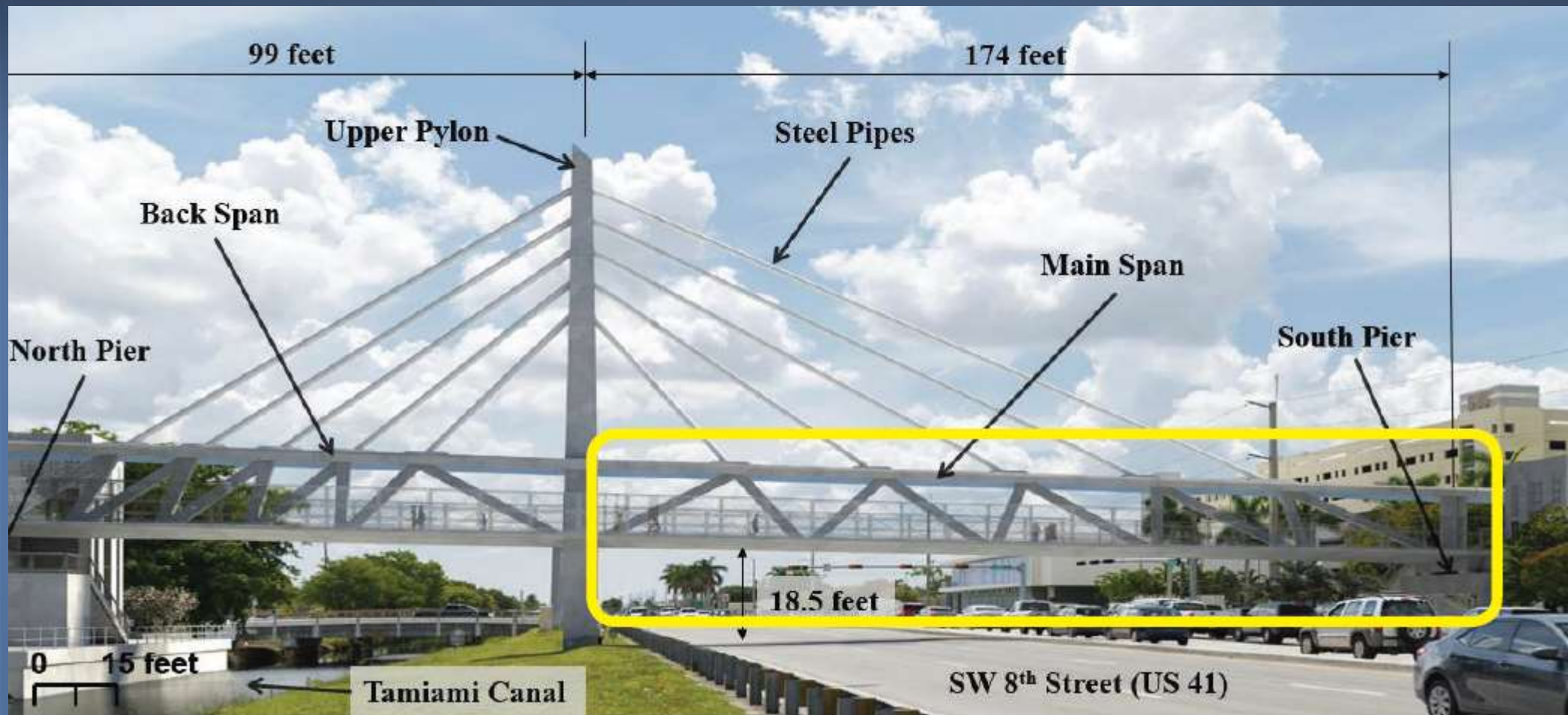
Walkway



NTSB



NTSB



Miami 3:53 PM

WFOR

BREAKING NEWS

POLICE: SEVERAL FATALITIES IN BRIDGE COLLAPSE AT COLLEGE IN MIAMI

Several cars trapped under pedestrian bridge at Florida International Univ

MIX-UP COMES AFTER A FRENCH BULLDOG DIED MONDAY ON A UNITED FL

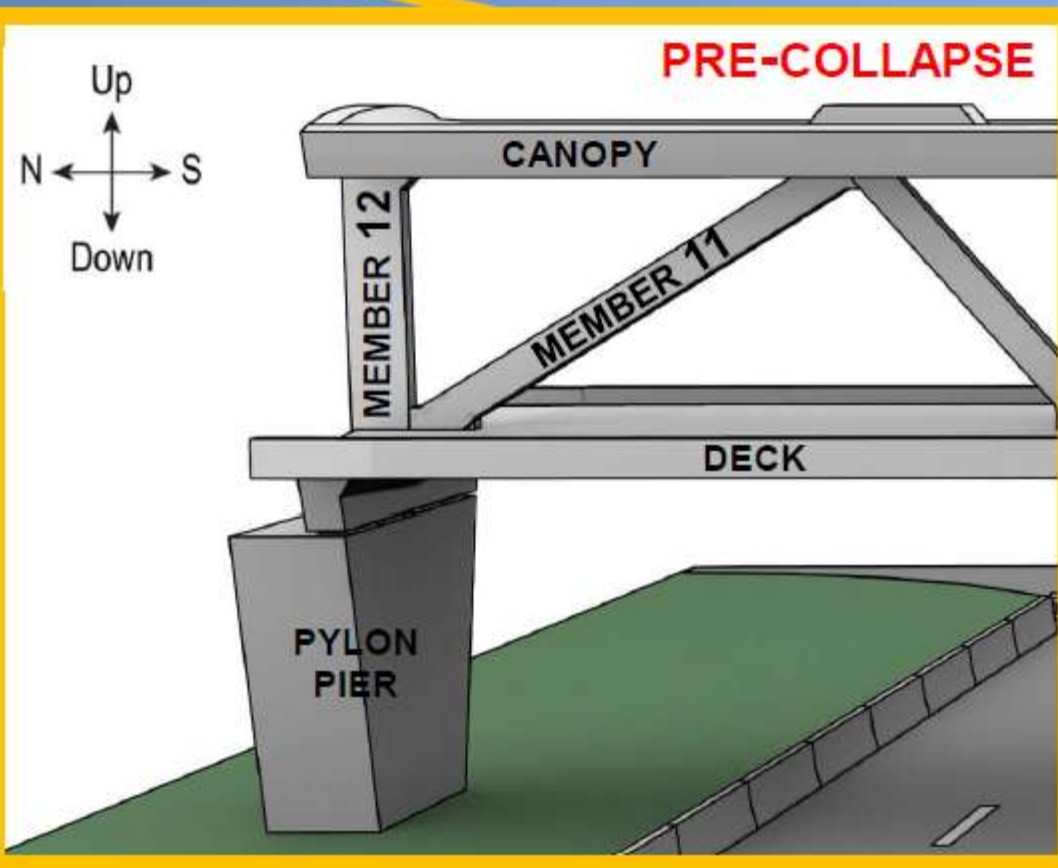
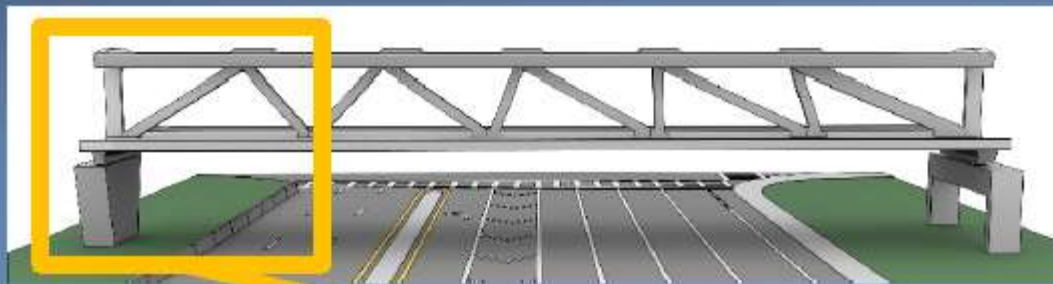
LIVE CNN

DOW ▲ 122.77

NEWSROOM

Facing East

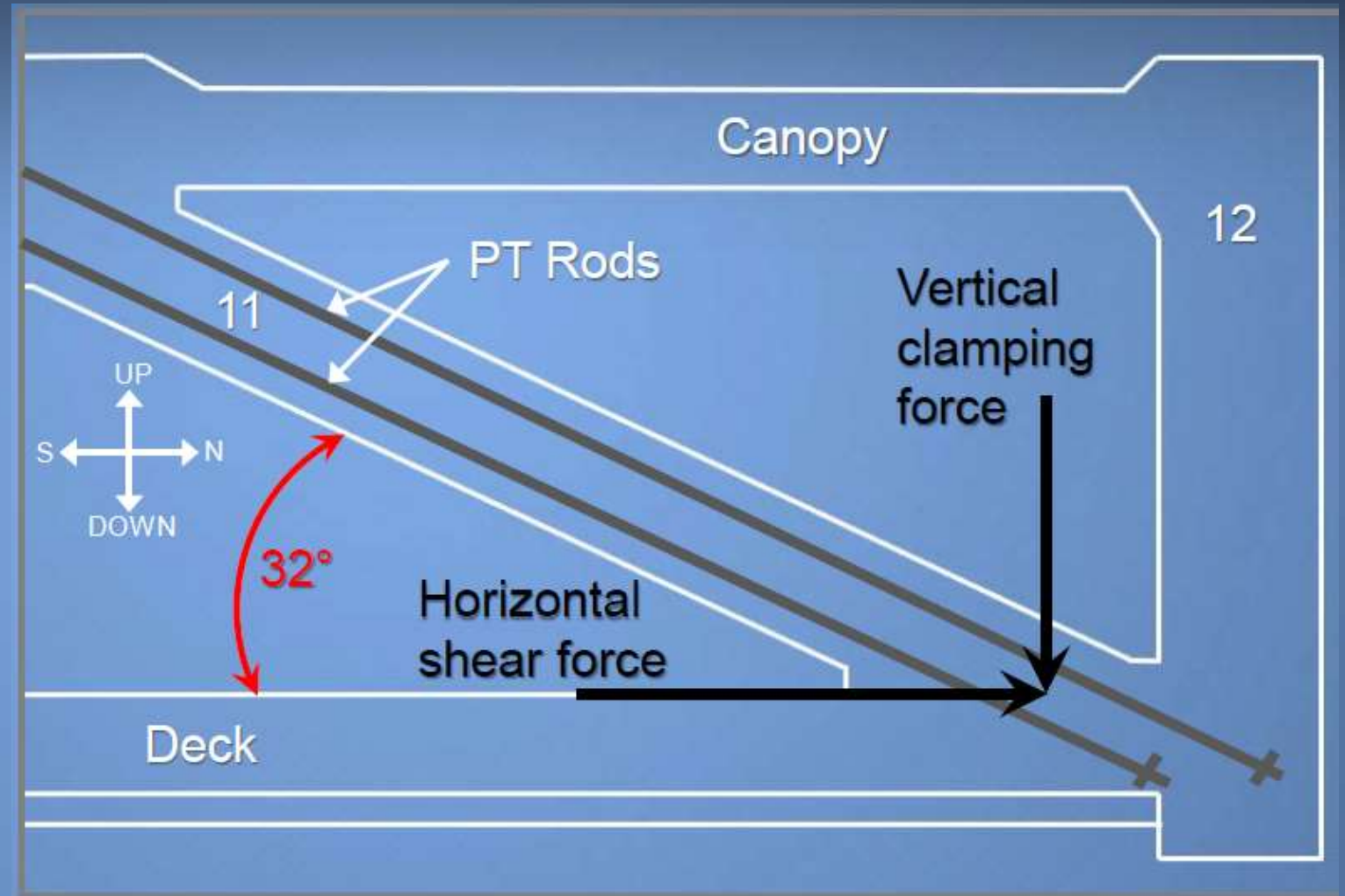


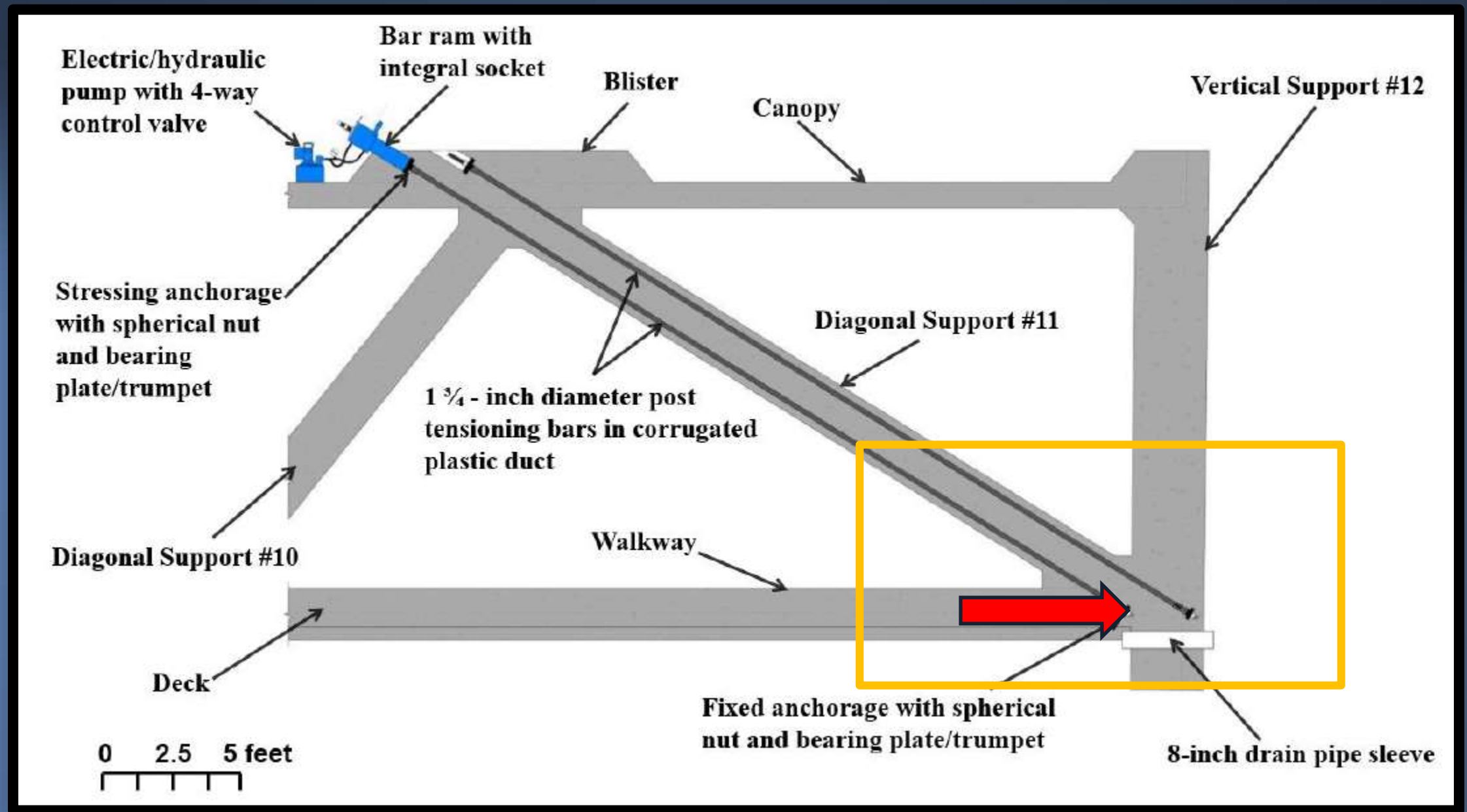


Facing East

Magnitude of
horizontal force –
60 percent larger
than vertical force

Facing West





Facing West





Critical Errors

- Bridge was under-designed
- Peer review was insufficient
- Failure to close bridge to traffic and workers

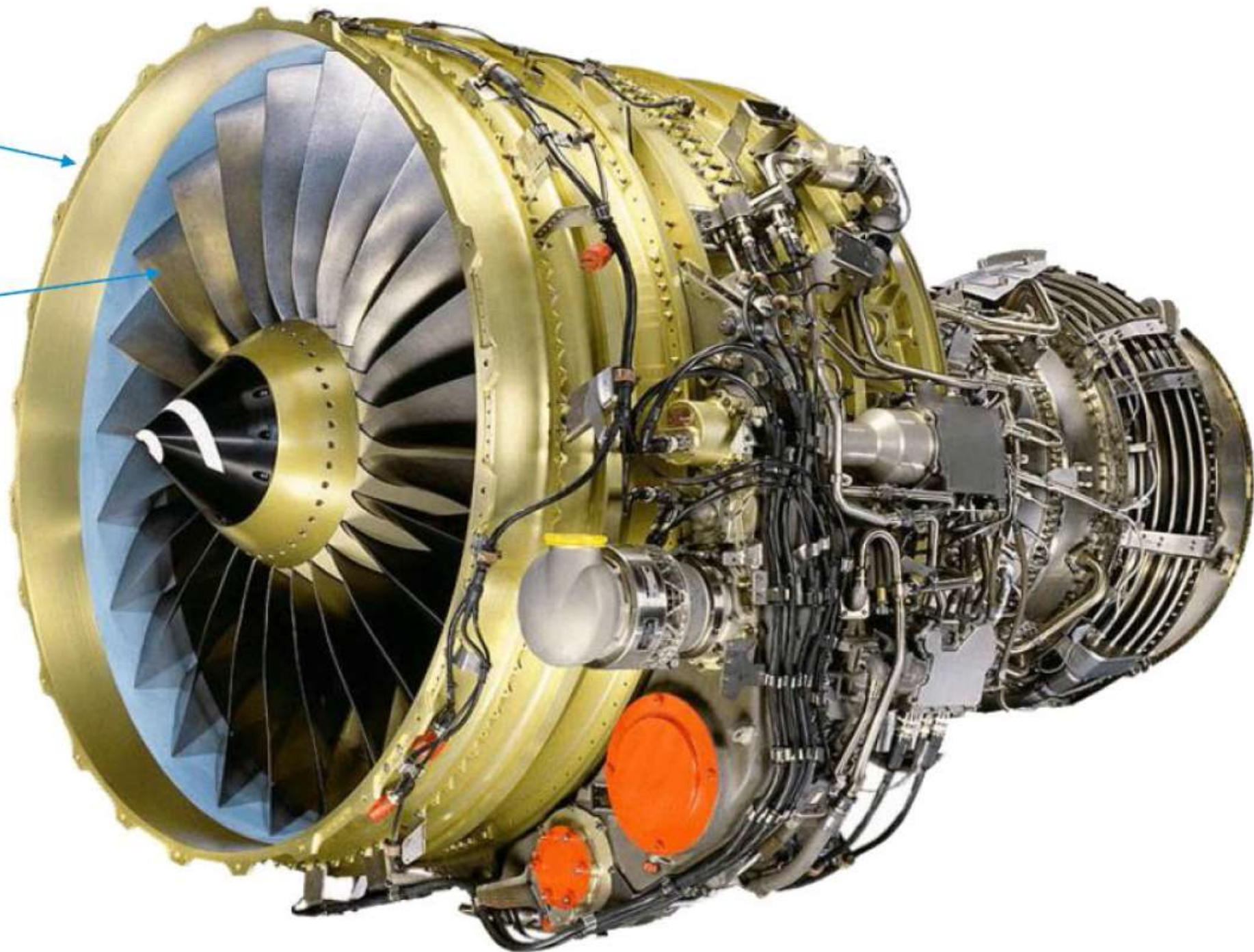
Southwest Airlines 1380

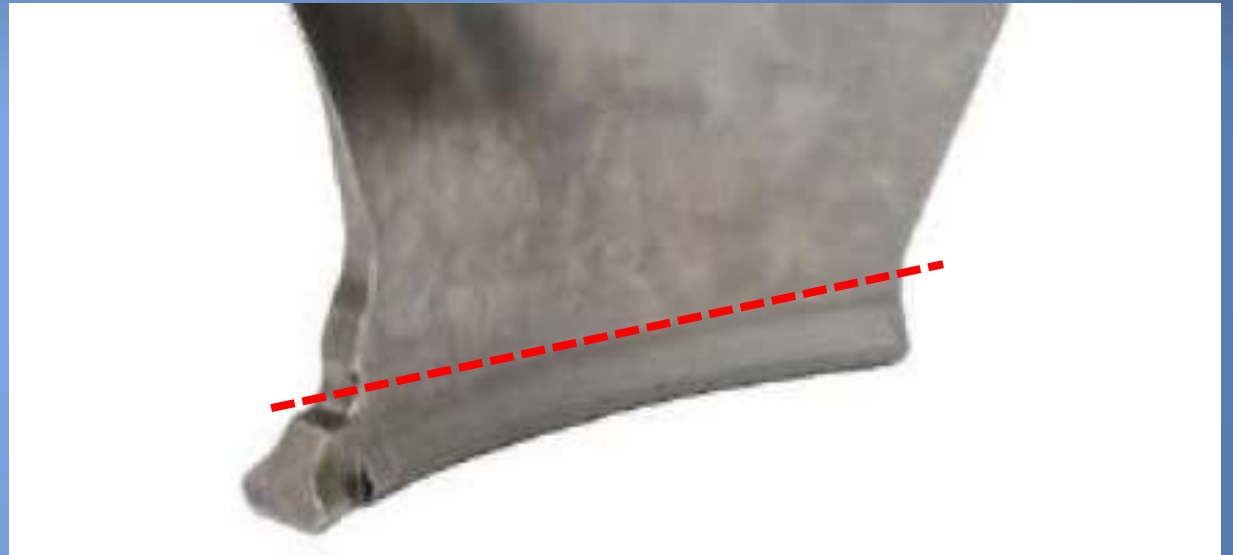
April 17, 2018



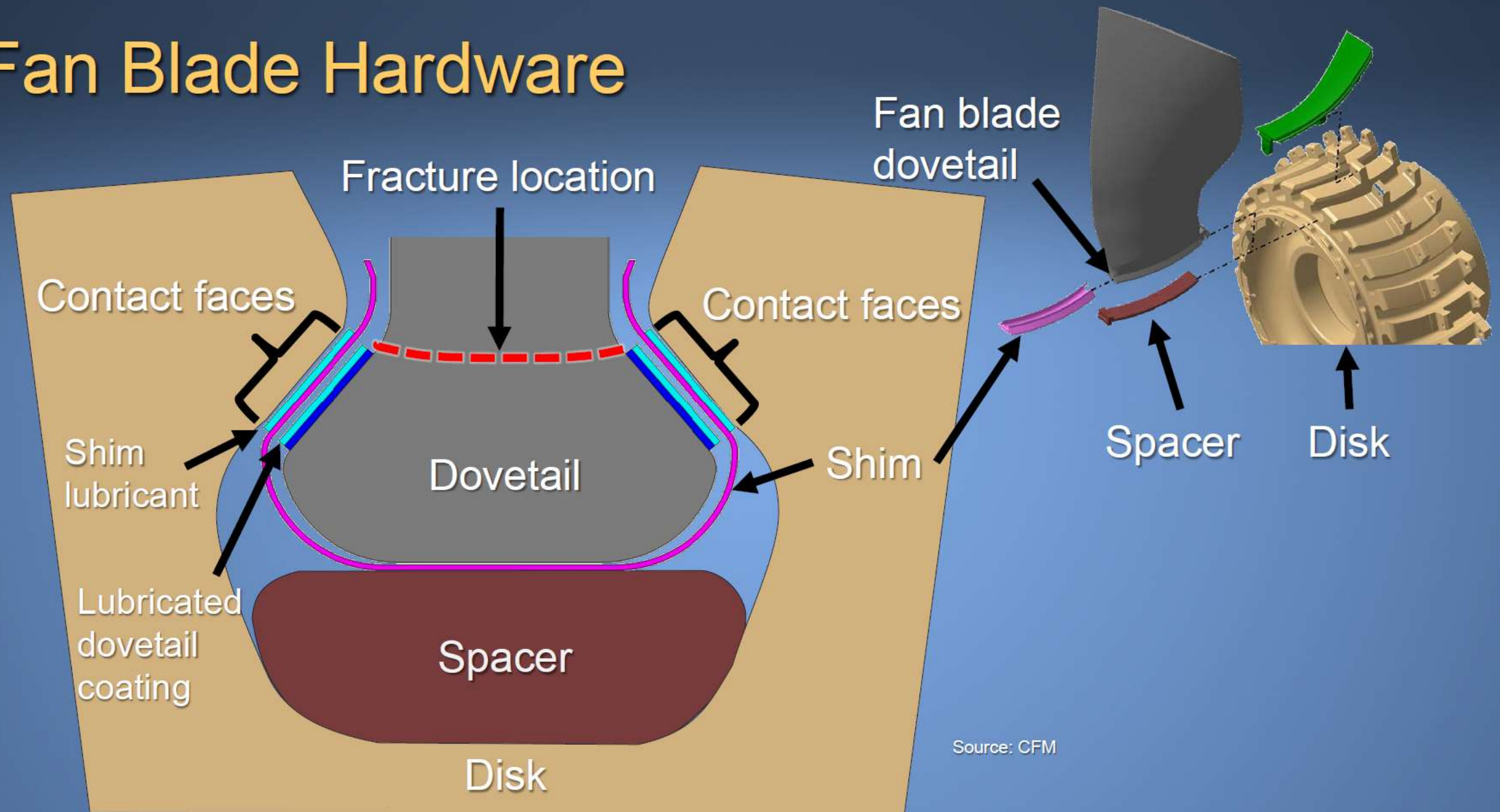
Fan Case

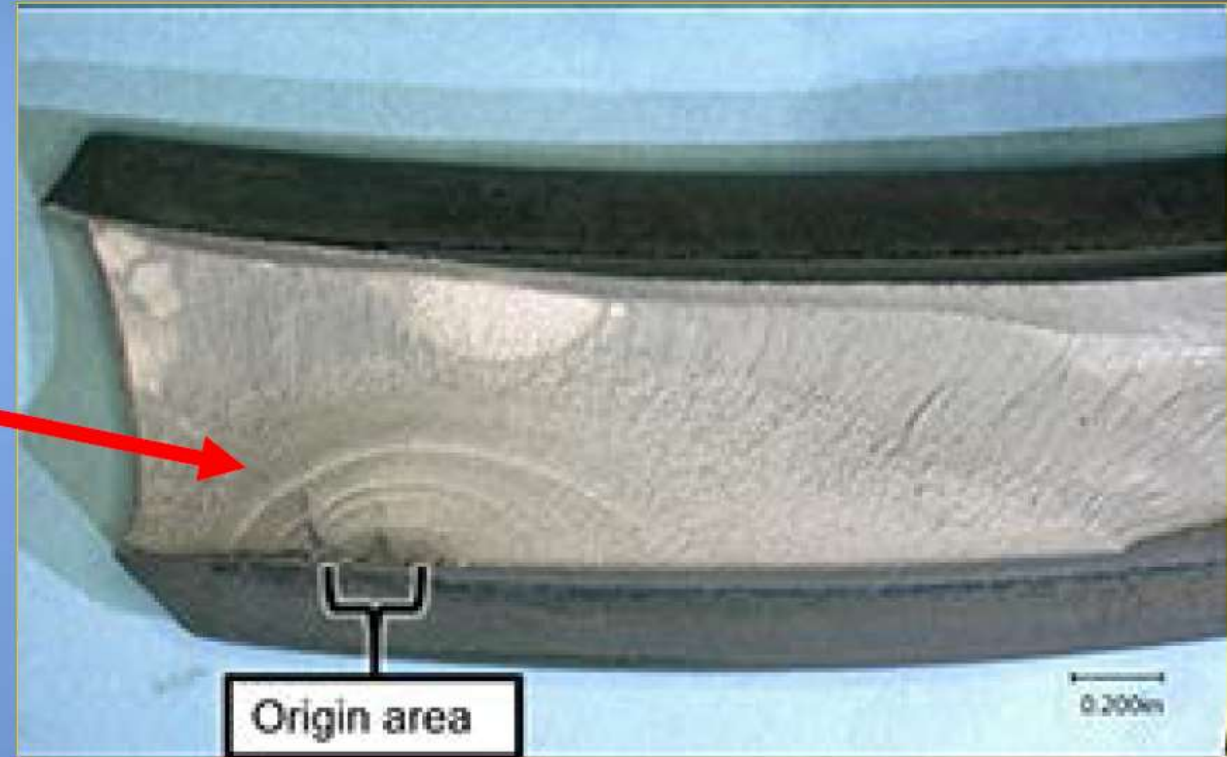
Fan Blade

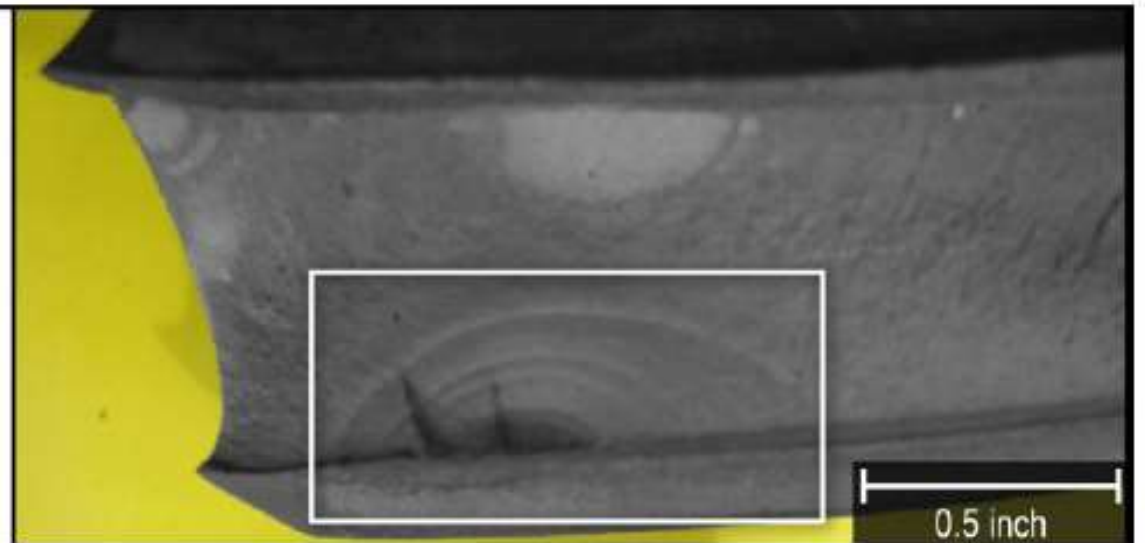
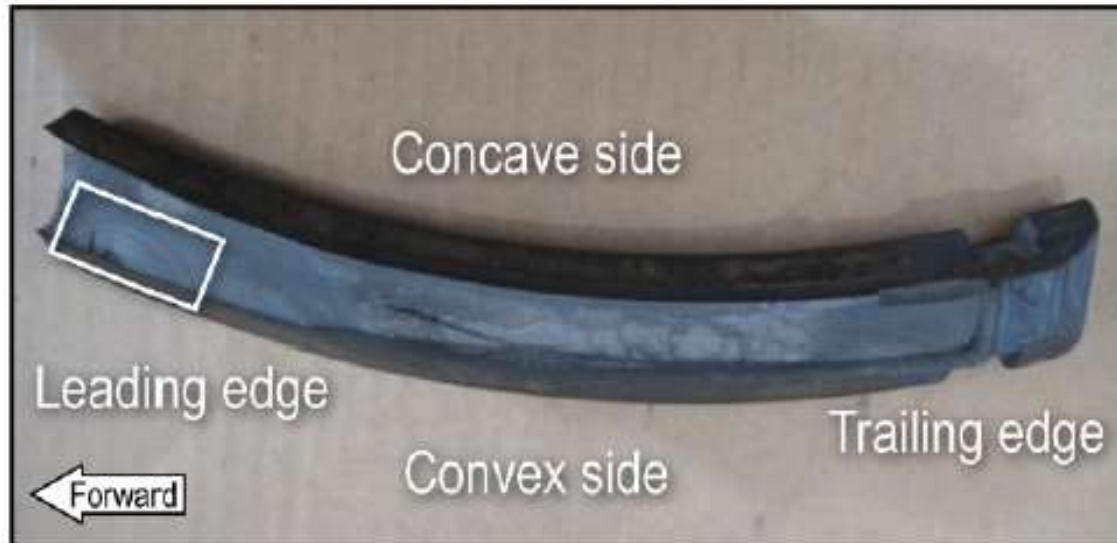


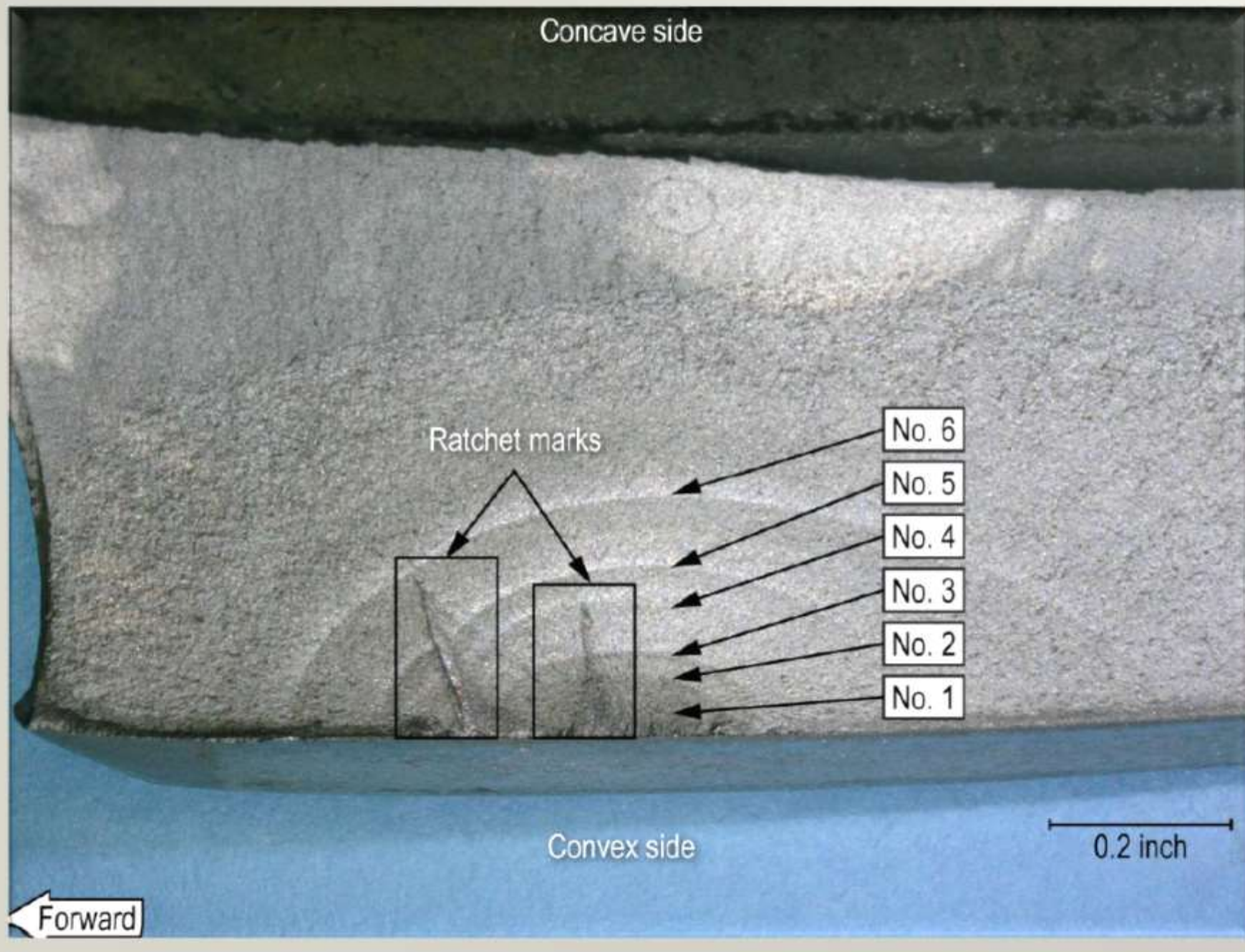


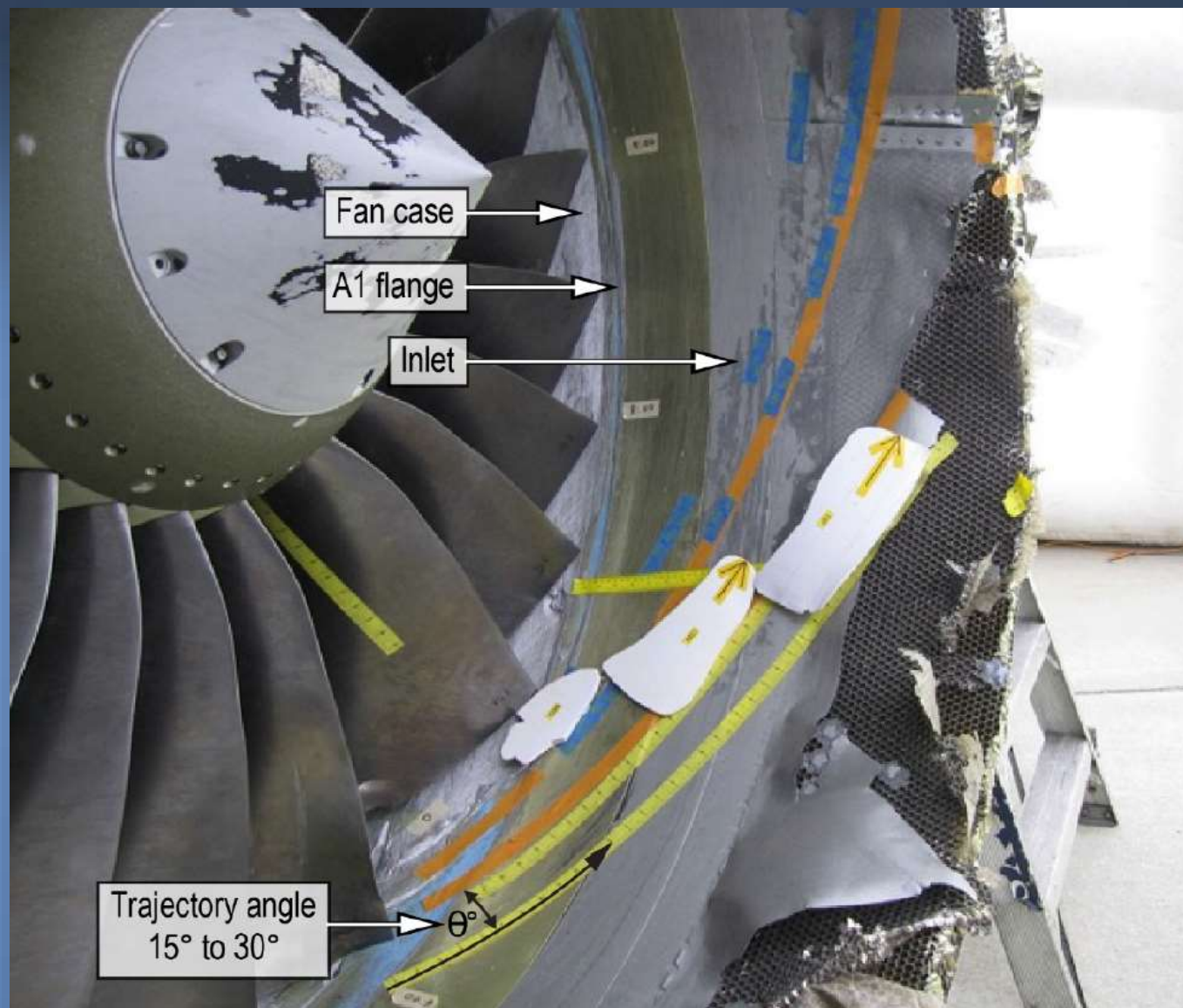
Fan Blade Hardware

















The National Transportation Safety Board (NTSB) determines that the probable cause of this accident was a low-cycle fatigue crack in the dovetail of fan blade No. 13, which resulted in the fan blade separating in flight and impacting the engine fan case at a location that was critical to the structural integrity and performance of the fan cowl structure. This impact led to the in-flight separation of fan cowl components, including the inboard fan cowl aft latch keeper, which struck the fuselage near a cabin window and caused the window to depart from the airplane, the cabin to rapidly depressurize, and the passenger fatality.



Tempe, Arizona
March 18, 2018





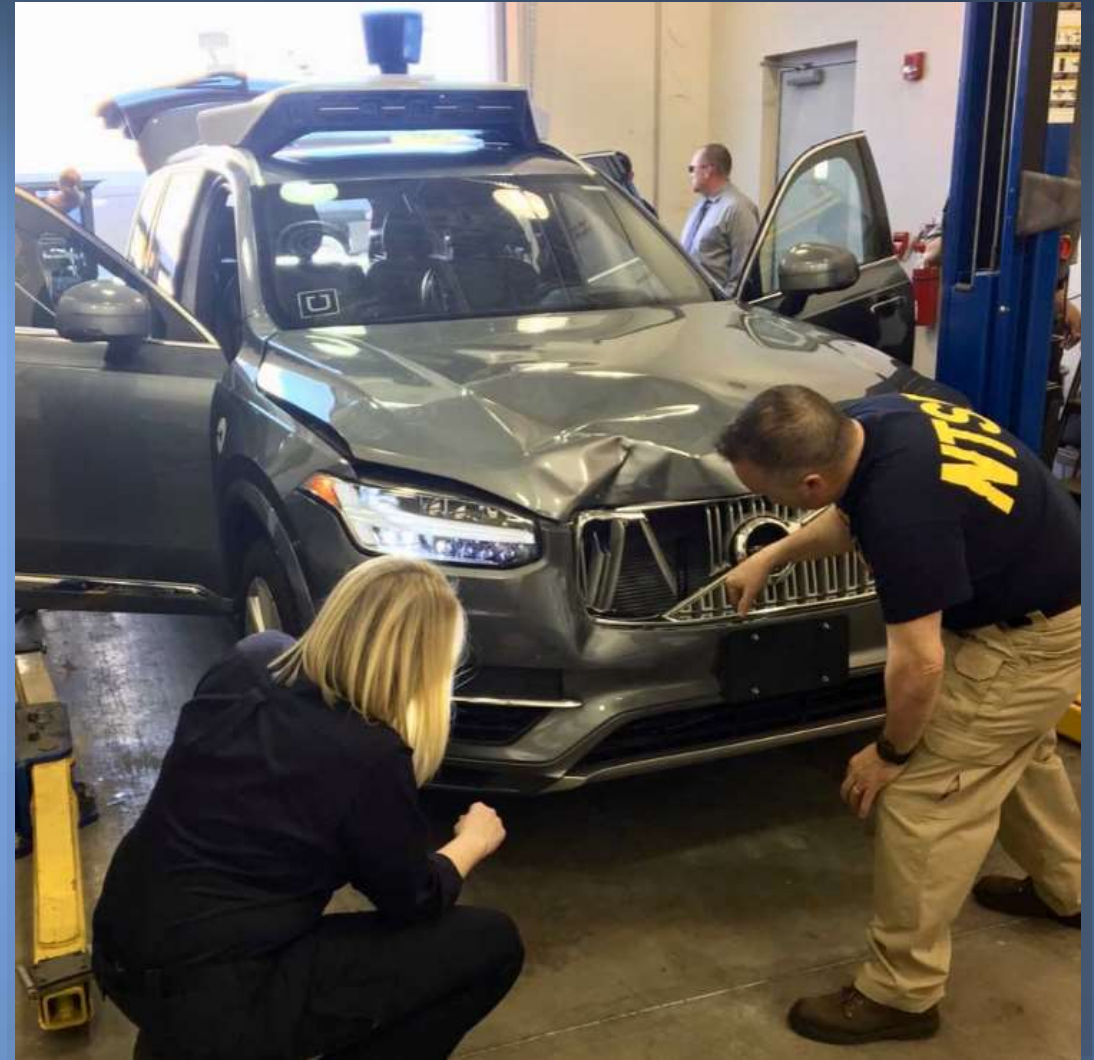
Crash Overview

- Sunday, March 18, 2018
- 9:58 p.m.
- Tempe, Arizona
- North Mill Avenue
- Automated test vehicle
- Night, dry, illuminated roadway
- 1 fatality, pedestrian



Crash Overview

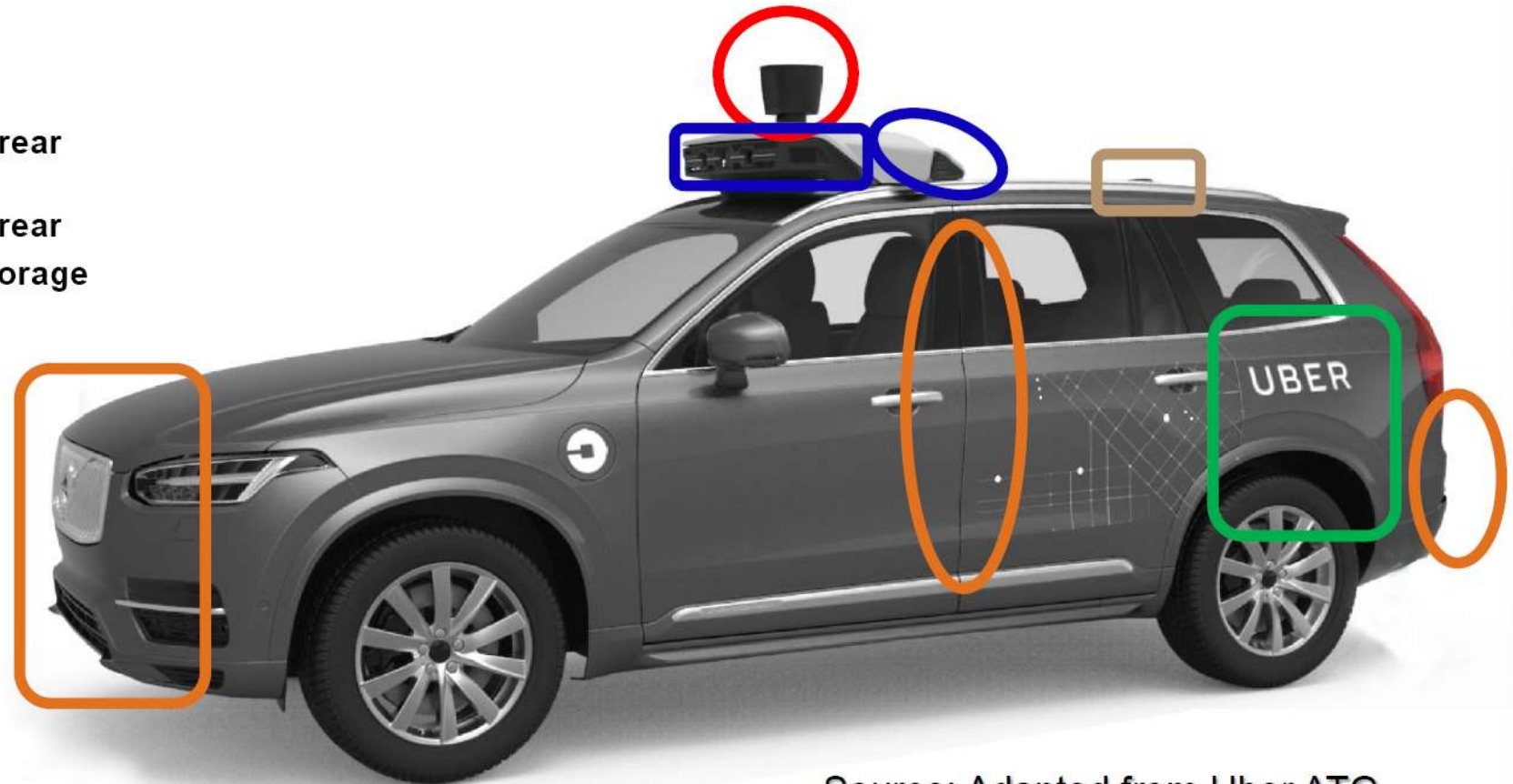
- Test vehicle based on modified 2017 Volvo XC90
- Uber ATG developmental automated driving system (ADS)
- Female operator occupied driver's seat
- Test vehicle was under ADS control



Test Vehicle: ADS Sensors

Systems

- Lidar
- Camera
 - Forward ○ Side and rear
- Radar
 - Forward ○ Side and rear
- ADS computing and data storage
- Telecommunication (GPS)



Source: Adapted from Uber ATG

Crash Sequence

**Pedestrian
Position 1.2 s to impact**

**44.8 MPH
4.2 s to imp**

**44.6 MPH
2.6 s to impact**

**43.2 MPH
1.2 s to impact**

**39 MPH
impact**



Perception and Motion During the Crash



Time to crash:	5.6 seconds
Classification:	Vehicle
Predicted path:	None

Perception and Motion During the Crash



Time to crash: 3.9 seconds
Classification: Vehicle
Predicted path: Left lane

Perception and Motion During the Crash



Time to crash:	2.6 seconds
Classification:	Bicycle
Predicted path:	Static

Perception and Motion During the Crash



Time to crash: 1.5 seconds
Classification: Other
Predicted path: Static, partially
on vehicle's path

Perception and Motion During the Crash



Time to crash: 1.2 seconds
Classification: Bicycle
Predicted path: Fully on path
of the vehicle
Braking suppression begins

Perception and Motion During the Crash



Time to crash: 0.2 seconds
Classification: Bicycle
Predicted path: Fully on path
of the vehicle
Braking suppression ends

Perception and Motion During the Crash



- Vehicle operator initiated steering 20 msec before impact

The National Transportation Safety Board determines that the probable cause of the crash in Tempe, Arizona, was the failure of the vehicle operator to monitor the driving environment and the operation of the automated driving system because she was visually distracted throughout the trip by her personal cell phone. Contributing to the crash were the Uber Advanced Technologies Group's (1) inadequate safety risk assessment procedures, (2) ineffective oversight of vehicle operators, and (3) lack of adequate mechanisms for addressing operators' automation complacency—all a consequence of its inadequate safety culture. Further factors contributing to the crash were (1) the impaired pedestrian's crossing of N. Mill Avenue outside a crosswalk, and (2) the Arizona Department of Transportation's insufficient oversight of automated vehicle testing.



Pedestrian Safety



National
Transportation
Safety Board

Selective Issues in School Bus Transportation Safety: Crashes in Baltimore, Maryland, and Chattanooga, Tennessee



Special Invest



National
Transportation
Safety Board

Reducing Speeding-Related Crashes Involving Passenger Vehicles



Safety Study
NTSB/SS-17/01
PB2017-102341



National
Transportation
Safety Board



NTSB

Vulnerable Road Users





Countermeasures

- Vehicle-based
- Infrastructure planning for pedestrian safety
- Improved pedestrian safety data

Vehicle-based countermeasures

- Vehicle physical designs
- Vehicle headlight performance
- Collision avoidance technologies

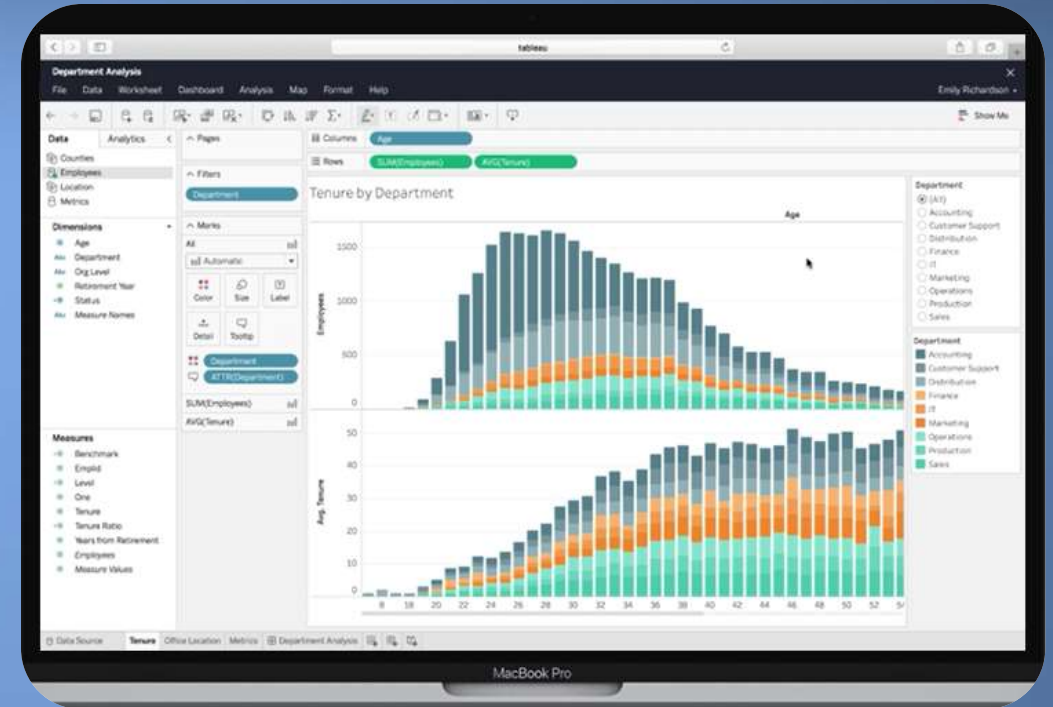


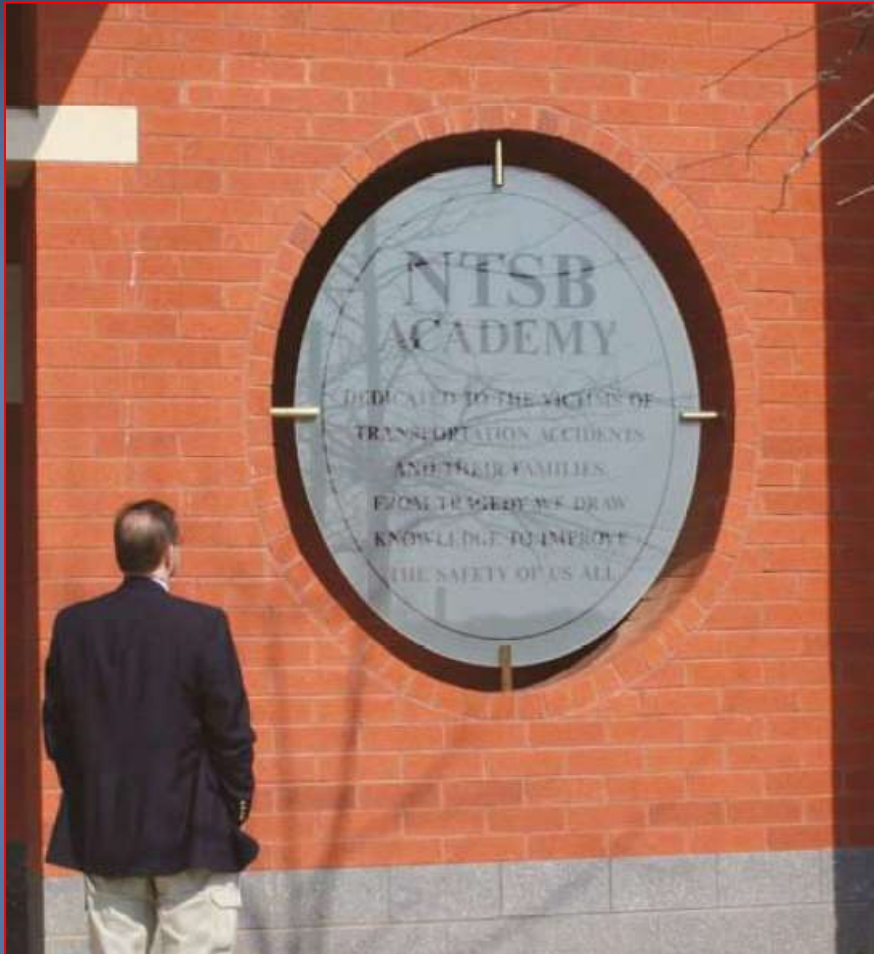
Infrastructure planning for pedestrian safety

- Pedestrian safety action plans
- Design guides
- Expanding local site-specific planning activities

Improved pedestrian safety data

- Pedestrian exposure data
- Crash data for system development and research
- Improved aggregated event data





“From tragedy we draw knowledge to improve the safety of us all.”



National Transportation Safety Board